CAH Coalition
CRITICAL ACCESS HOSPITAL COALITION

A VOICE FOR ESSENTIAL RURAL HOSPITALS

February 2, 2018

Marlene H. Dortch, Secretary
Federal Communications Commission
445 12th Street, S.W.
Washington, DC 20554

RE: Promoting Telehealth in Rural America – WC Docket No. 17-310

Secretary Dortch,

The Critical Access Hospital (CAH) Coalition appreciates the opportunity to comment on the Notice of Proposed Rulemaking and Order in the Rural Health Care (RHC) program (NPRM and Order). In particular we wish to comment on the proposed RHC funding cap increase and expanding the definition of "health care provider" to include critical access hospitals.

The CAH Coalition is a consortium of innovative health care leaders representing Critical Access Hospital (CAH) facilities across the country. The CAH Coalition advises policy makers on the unique needs of these small, rural hospitals to ensure resources are available for rural health care for generations to come. The CAH Coalition develops proactive solutions, determines best practices, and advocates on behalf of CAHs and rural communities. The CAH Coalition's sole purpose is to assist policy makers to understand the unique needs of CAHs so that high quality health care is sustained in rural communities.

Specific Comments

The CAH Coalition applauds the Commission's recognition that the Rural Health Care (RHC) Program is in dire need of modifications. The CAH Coalition agrees with some recommendations and disagrees with others, but the NPRM and Order have provided a pathway to align the goals of the RHC program among applicants and Universal Service Administrative Company (USAC) to improve efficiency, increase program reach, reduce administrative burdens, and curb waste, fraud, and abuse.

The cap on RHC funding has remained static since the program's inception, at which time support was limited to T1 or less. As technology advanced and telemedicine was implemented, the Commission modified the rules to allow for the advancements but failed to make financial adjustments to address the impact. The CAH Coalition supports adjusting the cap annually by inflation, from inception. The CAH Coalition also supports the suggestion to roll over funds from previous years, to be distributed without prioritization. We agree that USAC administrative costs should not reduce the funds available to health care providers (HCPs).

Currently, multi-year commitments are deducted from the funding year in which they were requested/approved. The CAH Coalition suggests that multi-year commitments be allocated to the funding year in which the funds will be used, without impacting the following funding year's cap for multi-year commitments and upfront costs.

The CAH Coalition is concerned with the suggestion to provide prioritization of funding to rurality. The definition of rural area in §54.600(b) of the Commission's rules meet the needs of the RHC Program and the CAH Coalition is concerned about any update or modification to the definition. While understanding that rurality is the driving force between rural market rates, the CAH Coalition does not agree to a tiered or prioritization based approach. Many CAHs are located in states that would not be considered tier 1 under the proposed definition; however these hospitals are over 35 miles away from the next nearest hospital and should be subject to the same priority as rural hospitals in other states.

The CAH Coalition does not support the proposed requirement that would mandate a healthcare-service relationship between a consortium's non-rural and rural HCPs that receive Program support, but does support reduction of the consortia grace period to one year.

To promote efficiency and reduce waste the Commission has suggested benchmarks for identification and enhanced scrutiny of outlier funding requests. The CAH Coalition supports enhanced controls, but establishing benchmarks based upon a previous year's data will not be an accurate indicator. In many regions, rural HCPs have a single service provider available which leaves them with no bargaining power. The CAH Coalition believes service providers within the program need to be held at a higher level of standards and bear the burden of their compliance verification. Intentional violations should be met with swift and direct consequences to the service provider, not the unknowing HCP.

The CAH Coalition supports ways to streamline and improve efficiency and agrees with the proposal to use four forms, eliminating the need to switch between programs. The CAH Coalition also supports unified data collection on RHC support impact, so long as the data collection and review process does not cause delays in processing funding requests.

CAHs are experiencing extreme financial impacts to their operational budgets due to the unforeseen extended delay in the processing of FY 2017 applications. In funding years 2013-2016, some facilities saw funding applications process in an average of 62 days – which was exacerbated by the implementation of the second filing window in 2016. If the FY 2016 window is excluded from the calculation, the average processing time was 43 days. In FY 2017, some applicants have waited more than 10 months with little to no update regarding the status of their applications. Since service providers require payment, HCPs are forced to stretch already limited budgets. FY 2017 is at a halt and FY 2018 filing has already begun with an aspect of uncertainty and questions of program stability; impacted facilities will not be able to determine need vs. budget.

The CAH Coalition would like to update the Commission's current definition of "health care provider." The Commission lists "health care provider" as: post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; community health centers or health centers providing healthcare to migrants; local health departments or agencies; community mental health centers; not-for-profit hospitals; rural health clinics; skilled nursing facilities; and consortia of those entities. In this definition, critical access hospitals are not specifically mentioned. CAHs are rural hospitals with 25 or fewer acute care inpatient beds, and located more than 35 miles from another hospital (with some exceptions). There are over 1,300 CAHs across the US providing 24/7 emergency care services to rural communities. CAHs should be specifically listed as a health care provider to clarify that CAHs may participate in the RHC programs.

In conclusion, the CAH Coalition supports the initiative to increase program reach, promote efficiency, reduce waste and align the two RHC programs' forms in order to ease administrative burdens while streamlining overall processes. We respectfully disagree with certain measures that will prioritize funding among applicants, increase administrative burdens or hamper strategic growth, and expanded telehealth reach.

The CAH Coalition appreciates the opportunity to comment on this proposed rule and is pleased to answer any specific questions you may have regarding our comments. If you have any questions, please contact the Executive Director of the CAH Coalition, Audrey Smith, at 202-266-2660 or through email at audrey.smith@cahcoalition.com.

Sincerely,

Audrey Smith
Executive Director
CAH Coalition